the Western States. Until these two figures increase dramatically and reach a more equitable proportion, a large segment of the blind population will find electronic mobility aids unavailable to them for lack of local instructors.

Currently, the cost of electronic aids is high--approximately $2,000 for each of the three main electronic devices. This high cost raises many serious questions in the minds of budget-minded administrators. Notwithstanding such costs, the new electronic mobility aids have now clearly shown themselves to have real merit. They will thus be a part of work for the blind from now on. Appropriate steps should be taken by administrators and Orientation and Mobility Specialists to insure that they are properly prepared and willing to maintain their high standards of leadership in the ever-expanding field of work for the blind.

REALISTIC ORIENTATION AND MOBILITY FOR THE ELDERLY BLIND PERSON

By

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The New York Infirmary/Center for Independent Living

The New York Infirmary/Center for Independent Living is a comprehensive rehabilitation center whose students are individuals legally blind and 55 years old or older. The Center for Independent Living (C.I.L.) was established three years ago with the belief that the student determines the direction and component of his rehabilitation program according to his personal needs. That is, when the student arrives he will express his rehabilitation needs and these needs will be the basis for his instruction. These needs become his goals and these goals are achieved through a highly individualized and interdisciplinary approach.

The concept of student-stated goals has many implications in a rehabilitation program. The student-oriented program required that the instructors and students be keenly aware of the student's curriculum, its rationale and its components with the instructor ready to restate the curriculum in terms of student-stated needs. This approach necessitates the student's awareness of what is involved in a total program as well as in each subject area so that he may intelligently select those parts leading toward completion of his self-set goals. A delightful result of this approach for the student is that the major portion of the rehabilitation program responsibility in terms of monitoring rests with the student. This offers an added feeling of freedom and control to discuss and change a program at any time.

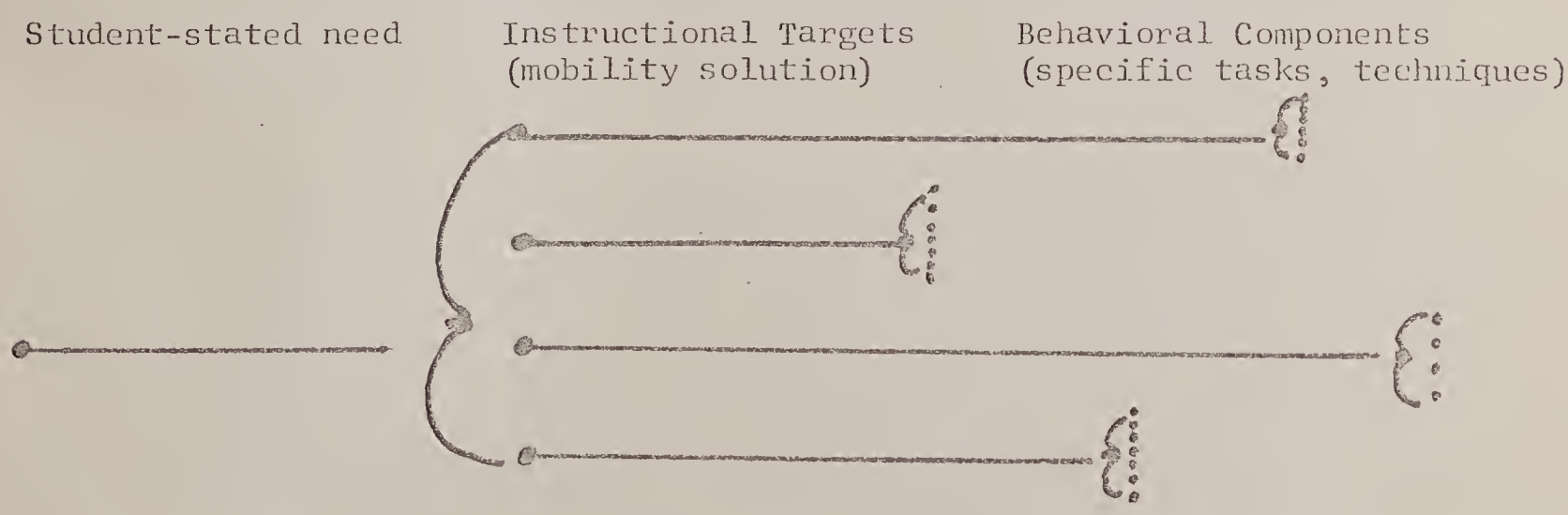
Experience within this approach has shown that the occurance of blindness is looked on by many students as an interruption in a well-established life pattern. As a result most individuals wish simply to return to their regulated

From: The Long Cane Newsletter, Vol. 9, No. 1, January 1976, pp. 12-15.

life pattern with as little change as possible. It is through this concept of student-stated goals and the common desire to continue with a set life pattern that the impact of the CIL's philosophy is felt on the orientation and mobility instruction.

The individual who decides to enter CIL usually has many needs that must be answered to regain independence. They oftentimes have many established ideas as to what they want stemming from the facts that they have established a definite desired life pattern and know exactly what they like and dislike. This causes a good deal of excitement and work for the instructors as they have to know how to redefine the student's stated needs to specific and justifiable orientation and mobility needs. Upon examination of all variables dealing with goal setting the mobility instructor and the student literally write a course prescription. The questions posed to the student deal with what they like to do, how blindness has inconvenienced them and what can the orientation and mobility instructor do to assist in achievement of desired goals. At this stage in an orientation and mobility course, the instructor may have to discuss at length with the student why so much of the responsibility is the student's. Most students will agree with these in theory but to be the decision-maker and follow them through is usually a first for any of our students as far as their educational experiences are concerned. This concept of the use of life patterns in establishing student goals at CIL can not be overly emphasized as it is the essential difference between orientation and mobility programs with other age populations and the orientation and mobility program at the New York Infirmary/Center for Independent Living.

As orientation and mobility instructors we are attempting to present a comprehensive and systematic mobility program which can be understood and monitored by the student. When a student states a travel need we analyze that travel need and redefine it for ourselves into instructional targets (i.e., mobility solutions). These targets, of which we presently have 24, are basically separate, distinct teaching units. These targets are used for both reporting and monitoring progress. We are presently attempting to break down each of these instructional targets into distinct behavioral components. These behavioral components would be the specific tasks and techniques involved. A schematic explanation follows:



For each student's stated need there could be a different target or sets of targets and consequently different behavioral components. It is through this individualized method that we develop the prescription for each student's orientation and mobility program.

While in our rehabilitation program the student is able to monitor his progress by being involved in every decision made concerning his program. Students attend and participate in every decision making meeting. These meetings, referred to as staffings, include the evaluation staffing, the monthly review staffings and the graduation staffing. Students are encouraged to invite family members and friends to attend these staffings. It is hoped that through family involvement now, family support will continue upon graduation. All reports and written material are shared with and in most cases written with the participation of the student prior to their staffings. All of the above is true for all subject areas at C.I.L.

Given the definition that orientation and mobility training is the development of a system allowing a visually impaired individual to control his movements within an environment to ensure maximum safety, cane techniques have not proven to be a problem. Technique modifications do force the instructor to be flexible as well as forcing the instructor to analyze all the components of the technique so that he can safely adapt as need be. We utilize the Typhlo cane, the Mahler heavy duty collapsible, the Hycor autosupport cane and the Hycor autofold. However, on student request we have taught with a white wooden cane. We are also presently planning to investigate the use of the fiberglass cane specifically for our students with impaired feeling in their fingers.

Many of the problems we have in dealing with this age group are health related. Because of the age range of our population, we expect and find many additional medical problems. Some of the more common health disorders are advanced diabetes and related ailments, osteoarthritis, emphysema, high blood pressure, artereosclerosis, aneuryism, amputation, heart problems, foot problems and organic brain disorder. Hearing losses are also a major and common concern. Included in every student's initial evaluation is an audiological examination. The results have shown that most of our students have some degree of hearing loss due to many factors. As one would expect the hearing losses have a great effect on the student's ability to discriminate, localize and utilize sounds. This requires a greater emphasis on the use of sighted assistance in their training. Many students receive hearing aids while enrolled in the CIL program. They then have the added difficulty of re-adjusting to their new hearing while learning how to use the aids. This difficulty is dealt with by our sensory development instructor in conjunction with the orientation and mobility instructor.

Similar to the national population of the visually impaired the majority of our students have some degree of residual vision. We emphasize the use of this residual vision in conjunction with the low vision distance aids prescribed by our consulting specialist. The students in many cases resist this attempt to maximize use of their residual vision. This resistance generally takes three forms: one being the attitude, both realistic and unrealistic in that they are going to lose their residual vision so therefore should learn as a totally blind individual; another being the inability to coordinate their residual vision with the use of their other senses; and, finally, many students find adapting to the new method of traveling with the low vision aids too difficult and tedious.

Many of our students have been physically dormant for some time and are not able to stand the rigor of attending a rehabilitation center or be involved in an orientation and mobility program. This causes the initial lessons to be shortened Many lessons start with a cup of coffee, not so much for socializing purposes but for "reving" the student. Eventually the student and instructor are able to work up to the usual forty-minute lesson. Diabetics often have a serious problem with the increased activity. The physical dormance has caused movements to become rigid as manifested in many types of body movement control difficulties. To combat this we have a body movement instructor who is specially trained to deal with the problems of this age group. These problems should not be under-estimated as they are the same type found in other adventitiously blinded age groups but are aggravated by our students' age. Another problem of this type is the frequent stated attitude by our students that they are too old to learn. This is difficult to combat and one approach is to demonstrate progress through our student oriented and monitored program. The CIL monitoring system affords the student the opportunity of daily and periodic self-evaluation.

To deal with these problems, we are fortunate to have the total rehabilitation process and personnel to assist the orientation and mobility instructor. At CIL we have the casework and psychological services to assist with the psychosocial problems, a staff of medical consultants to handle medical problems, a body movement instructor to assist with alleviating the rigid movements and a sensory development instructor. Our sensory development instructor works in conjunction with the orientation and mobility instructors to compliment training by intensifying work in any area that is found insufficient in orientation and mobility. It should not be thought that sensory development is only a part of orientation and mobility. It is an entire course unto itself and deals with many areas that orientation and mobility instructors do not deal with directly.

Orientation and Mobility instruction at the Center for Independent Living is in essence no different than instruction with any other age group. We teach the same safety skills, the same movement techniques and attempt to develop the same orientation logic. The differences are in the attitudes towards and the respect of the individuals involved. With an older blind person, whose life pattern is set, the orientation and mobility program compliments, respects and works within the framework of that life pattern. Many times to do this some refinements of orientation and mobility training might have to be cut away. This process often causes instructor frustration, but it is necessary to present a reality based and prescribed program which satisfies the self-stated needs of the student and recognizes their right to self-determination.

A GUIDE DOG* INSTRUCTOR'S VIEWS
MOBILITY: AN INTERDISCIPLINARY SERVICE

By

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